ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Involuntary Reinstatement from Industrial Disability Retirement of: TRACEY A. PORTEE, Respondent, and DIVISION OF ADULT PAROLE OPERATIONS (NORTHERN REGION), CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondent.	Case No. 2017-0609 OAH No. 2017080395

PROPOSED DECISION

This matter was heard before Danette C. Brown, Administrative Law Judge, Office of Administrative Hearings, State of California, on February 23, 2018, in Sacramento, California.

Cynthia Rodriguez, Senior Staff Attorney, represented California Public Employees' Retirement System (CalPERS).

Tracey A. Portee (respondent) was present and was represented by Craig Dykman, Attorney at Law.

There was no appearance by or on behalf of the Division of Adult Parole Operations (Northern Region), California Department of Corrections and Rehabilitation (CDCR). Proper service of the Accusation and Notice of Hearing was made to CDCR. The matter proceeded as a default against respondent CDCR, pursuant to Government Code section 11520.

Evidence was received, the record was closed, and the matter was submitted for decision on February 23, 2018.

ISSUES

Did CalPERS establish that respondent is no longer substantially incapacitated from performing the usual duties of a Parole Agent I and should therefore be reinstated from industrial disability retirement?

FACTUAL FINDINGS

1. Respondent was employed by CDCR from 1995 to 2011. She began working as a Parole Agent I in 2004, and worked in that capacity until her injury in 2011. Prior to working as a parole agent, respondent worked as a correctional officer from 1995 to 2004. On or about September 24, 2012, respondent applied for industrial disability retirement. Respondent's application was granted, and she disability retired effective April 15, 2013, on the basis of an orthopedic (right shoulder) condition.

Duties of a Parole Agent I

2. As set forth in CDCR's Division of Adult Parole Operations Region 1 Duty Statement for Parole Agent I, the Parole Agent I is responsible for the supervision and casework services of parolees assigned to a field unit. Agents supervise and monitor behavior, investigate parole violations, apprehend and arrest parolees, and develop community resources.

3. As set forth in CDCR's Division of Adult Parole Operations, Parole Agent I Essential Functions (Essential Functions) document, parole agents must have the ability to perform essential functions, including:

> (a) Conducting surveillance, search and seizure, apprehending and arresting parolees;
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> (b) Disarming, subduing and applying restraints;
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> (c) Self-defense and defense of others;
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> (d) Searching for contraband in buildings, homes, vehicles; conducting body searches as required;
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> (e) Range qualifying every quarter with department-approved weapons;
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> (f) Qualifying with the expandable baton;
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> (g) Utilizing appropriate safety equipment and protective clothing (bullet-proof vests, etc.);

(h) Moving the head and neck throughout the workday, including observing and surveillance of parolees;

(i) Moving arms when writing reports and restraining individuals;

(j) Exiting from a stopped vehicle quickly in emergency situations.

4. A CalPERS form entitled "Physical Requirements of Position/Occupational Title" sets forth the Physical Requirements Information for a Parole Agent I. A Parole Agent I occasionally[1] performs the following activities: sitting, standing, running up to 300 yards, walking up to 1.5 miles, crawling up to 50 yards, kneeling, climbing up to 150 steps, squatting, bending (waist), reaching (above shoulder), reaching (below shoulder), pushing and pulling, keyboard use, mouse use, lifting and carrying from 51 to over 100 pounds up to 200 yards, walking on uneven ground up to 1.5 miles, driving up to eight hours, exposure to excessive noise, exposure to extreme temperature, humidity and wetness, exposure to dust, gas or chemicals, working at heights, operation of foot controls or repetitive movement, use of special visual or auditory protective equipment, and working with bio hazards.

A Parole Agent I frequently[2] performs the following activities: sitting, standing, walking up to 1.5 miles, climbing up to 150 steps, bending (neck), bending (waist), twisting (neck), twisting (waist), reaching (below shoulder), pushing and pulling, fine manipulation, power grasping, simple grasping, repetitive use of hands, lifting and carrying 26 to 50 pounds up to 200 yards, walking on uneven ground up to 1.5 miles, driving up to eight hours, exposure to extreme temperature, humidity and wetness, exposure to dust, gas, fumes or chemicals, and working at heights.

A Parole Agent I constantly[3] performs the following activities: sitting, standing, walking up to 1.5 miles, bending (neck), twisting (neck), fine manipulation, power grasping, simple grasping, repetitive use of hands, lifting and carrying from zero to 25 pounds up to 1.5 miles, driving up to eight hours, and exposure to extreme temperature, humidity, and wetness.

The form was signed and dated on May 14, 2017 by CDCR's Return to Work Coordinator/Health and Safety Officer, but was not signed or dated by respondent.

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[1] "Occasionally" is defined as up to three hours.

[2] "Frequently" is defined as three to six hours.

[3] "Constantly" is defined as over six hours.

Respondent's September 24, 2012 Industrial Disability Retirement Application

5. Respondent submitted an industrial disability retirement application dated September 24, 2012. On a separate sheet of paper attached to her application, respondent described her specific disabilities as:

> Bulging discs and post annular tears in neck, possible Bursitis in right shoulder, chronic pain in neck, right shoulder and back.

Respondent described how her disabilities occurred:

> On March 11, 2011, I was driving my state issued vehicle. While pulling out of a parking lot, I was struck on the driver's side of my vehicle. I was taken to the emergency room where I was examined, x-rayed, given medication and sent home. I reported back to work on March 18, 2011, where I was unable to finish my work shift due to being in pain from my injuries. I have been off work since that day. I had a Chiropractor assigned as my treating physician. After 19 visits State Fund did not approve any more [*sic*].

Respondent described her limitations and preclusions due to her injury as:

> Due to my being in constant pain in my neck, shoulder and back, I am unable to perform my regular duties as a Parole Agent. I can no longer stand, sit, walk, or drive for longer than approximately 15 minutes before I am in a lot of pain. I am unable to run, climb, crawl, lift or carry over ten pounds, push or pull, or reach overhead. I am limited in my neck movement and am unable to twist my body with a full range of movement. I will not be able to swing an expandable baton or qualify quarterly with the expandable baton or firearm without causing myself further pain and injury. Given the weight, I will not be able to wear my duty belt. I do not feel as though I would be able to protect myself or my partner if put in a dangerous situation or be able to subdue or disarm a parolee if necessary. I cannot sit at a desk and work on a computer without my left arm feeling numb and tingling and experiencing a great deal of pain in my neck, shoulder and back. I am on medication including a muscle relaxer and hydrocodone which warns against driving a vehicle and can cause dizziness.

In response to the question asking how her injury or illness affected her ability to perform her job, respondent stated:

> I am unable to complete almost all the required essential functions and job duties of being a parole agent. One of the most important duties of a parole agent is to protect the public. I am no longer physically capable of protecting myself, other agents or the public. I am no longer able to do any of the physical duties of my job. I cannot do office or computer work without being in a great deal of pain. I cannot drive a vehicle for an extended amount of time. Regrettably, this injury has left me unable to perform all aspects of my job duties as a parole agent.

CalPERS' Approval of Respondent's Disability Retirement Application

6. On April 15, 2013, CalPERS sent a letter to respondent approving her application for industrial disability retirement "based upon [her] orthopedic (right shoulder) condition." The letter stated that respondent "may be reexamined periodically to determine [her] qualification for reinstatement" if she was under the minimum age for service retirement. Respondent was approximately 43 years old at the time she submitted her application for industrial disability retirement.

April 18, 2017 IME by Harry A. Khasigian, M.D.

7. In 2017, CalPERS sent respondent to Harry A. Khasigian, M.D., for an Independent Medical Examination (IME). Dr. Khasigian is a board-certified orthopedic surgeon. Dr. Khasigian has been in private practice as an orthopedic surgeon since 1979. He is affiliated with Methodist Hospital, Mercy General Hospital, Woodland Memorial Hospital, and Sutter Alhambra Surgery Center.

8. On April 18, 2017, Dr. Khasigian physically examined respondent, reviewed her history, medical records and job duties, and issued an IME report. Dr. Khasigian testified at hearing, consistent with his IME report, which was admitted in evidence.

9. Respondent told Dr. Khasigian that on March 11, 2011, while at work, she drove out of a parking lot when another car hit her in a "T-type fashion" on the driver's side. Respondent's head hit the steering wheel, and her right hip hit the gearshift. Respondent did not know how her right shoulder was injured, since the impact occurred on her left side.

10. Respondent complained of a constant, aching, dull, intense pain in her neck, "bone on bone" pain in her right shoulder, similar pain in her left shoulder, constant dull, aching pain in her upper mid-back with spasms, and "sometimes" aching and dull pain in her right hip.

11. Dr. Khasigian summarized respondent's diagnostic test reports in his IME report: (a) an undated report wherein respondent described her injuries as bulging discs and posterior annular tears in the neck; (b) a March 7, 2012 magnetic resonance image (MRI) of

her cervical spine, showing small posterior bulging discs at C4-5 and C5-6, with no canal or foraminal stenosis; (c) a March 10, 2014 MRI of the right shoulder, indicating "mild tendinosis, mild acromial joint osteoarthritis, and decrease in size of paralabral cyst;" (d) an October 1, 2014 operative report of an epidural steroid injection to the cervical spine; and (e) an August 2, 2016 MRI of the right shoulder, showing "limited interstitial tearing of supraspinatus," not a full-thickness tear.

12. Dr. Khasigian performed a physical examination of respondent. He took respondent's vital signs, observed respondent's movements, palpated her areas of pain, examined respondent's lumbar, thoracic and cervical spine, her shoulders, and upper extremities. Dr. Khasigian also performed a neurological examination, took measurements of respondent's upper arms and forearms, and measured her grip strength.

13. Dr. Khasigian noted that respondent did not have any swelling, masses, redness, induration, edema, or discoloration. Further, respondent did not have any distorted anatomy or malposition. Respondent's gait and station were normal, and Dr. Khasigian did not find evidence of scoliosis. Respondent had normal posture and alignment. Respondent's lumbar, thoracic and cervical spine had "normal clinical lordosis." There was no spasm or guarding. Respondent's shoulders were "held level." Her acromioclavicular (AC) joints were not prominent, and there was no deltoid or parascapular atrophy.

14. Dr. Khasigian noted that respondent's pain was located in the "posterior trapezius, not the AC joint and not the glenohumeral joint. She does not have any signs of impingement. There is no crepitus or grinding with range of motion. O'Brien's test is negative. Apprehension test is negative. The biceps tendon is normal. Bicipital groove is nontender and not swollen. The bicipital profile is normal."

15. In respondent's upper extremities, her pulses, hair distribution, skin turgor and temperature were normal. "Tinel's is negative at the wrists bilaterally. Tinel's is negative at the right elbow. Tinel's is stated to be painful on the left with a feeling of hitting the funny bone." Phalen's test was negative, even though respondent stated that she had a back spasm from "just sitting on the examination table."

16. Upon neurological examination, respondent was noted to have decreased sensation in the median and ulnar forearm. On the left, respondent had decreased sensation in the median and ulnar "in the hand." Respondent had increased sensation in "radial distribution." In respondent's lower extremity reflexes, sensory was "equal, symmetrical, and normal to pinwheel." Respondent's upper arm and forearm measurements on the right and left were substantially the same.

17. After examining respondent and reviewing her medical records and job duties, Dr. Khasigian provided the following diagnoses:

a. Musculoligamentous strain of the cervical spine-resolved;

b. Pre-existing and asymptomatic minimal cervical spondylosis without radiculopathy;

c. Minimal age and activity-related supraspinatus tendinosis without acute injury; and

d. Pain behavior.

18. Dr. Khasigian opined:

> Despite constant treatment and 6 years of non-work activities, [respondent] still states her pain level is an 8 in her neck and right shoulder. She has been in treatment on a monthly basis for over four years and had a cervical epidural and four cortisone injections in her shoulder and without the aggravation of work activities, still complains of a level 8 pain in the presence of a normal physical examination.
>
> The diagnostic tests that have been performed show pre-existing and activity related changes which are very minimal. The findings on the MRI are very close to normal and simply relate to minor age-related changes. There is no evidence of an acute traumatic lesion. There are no fractures or dislocations. There is no bone marrow edema. The minor changes in the disc are simply related to age. As the American Board of Radiology notes, her age group may have almost a 70 percent presence of bulging discs in asymptomatic individuals. Therefore, the combination of a minor change on an MRI and a normal neurological examination does not equate to an injury or impairment.

19. Dr. Khasigian also noted that respondent was hit on the opposite side of her right shoulder. "There is no demonstration of a mechanism that would produce a [right] shoulder injury [from her accident]." The findings on both MRIs were minor and related to a "dominant right-handed person's use of a shoulder[,] and are not representative of any type of acute traumatic lesion, particularly in the absence of demonstrable trauma." Dr. Khasigian opined that respondent's continued pain at level eight, six years without significant resolution over time, with treatment, was "not medically reasonable."

20. Dr. Khasigian concluded that with regard to respondent's right shoulder, she is capable of performing unrestricted activities, and there are no specific job duties that she is unable to perform. Similarly, with regard to respondent's cervical, thoracic and lumbar spine, there are no job duties respondent is unable to perform.

21. Dr. Khasigian further concluded that respondent is not substantially incapacitated based upon the "physical examination, minimal diagnostic tests, and the pain behavior exhibited that is nonphysiologic and does not determine any type of impairment." "The inconsistency between [respondent's] absence of impairment and her continued off work status are not based upon objective data that is represented in her records or current examination."

Respondent's Testimony/Evidence

22. Respondent testified that she worked as a correctional officer for nine years prior to becoming a parole agent in 2004. She asserted that she was in good physical condition prior to her accident. She took pride in being "in shape." Physical fitness was important because 90 percent of her parolees were men. Respondent asserted that she cannot perform her job safely today because of her current physical condition. She cannot protect herself or others. She cannot swing a baton, or use a firearm. She is in pain every day. She stated, "I don't know why I am in pain, but I just am." Respondent wishes to, but is unable to go back to work.

23. Respondent stated that she has had three MRIs, one of her neck and two of her shoulder. Respondent submitted an MRI report dated August 16, 2017 into evidence. In addition, respondent stated that she has had two cortisone injections from Dennis Douglas, M.D.[4], an orthopedic surgeon, and spoke to him about surgery. Dr. Douglas did not testify at hearing, and his medical reports were not submitted by respondent.

AUGUST 2, 2012 WORKER'S COMPENSATION EVALUATION BY JAMES HAN, M.D.

24. Respondent saw James Han, M.D., at the Comprehensive Pain Medicine Center, approximately three times. Dr. Han is board-certified in physical medicine and rehabilitation, and pain medicine. Dr. Han was respondent's worker's compensation qualified medical examiner, and performed an initial Qualified Medical Examination (QME) of respondent on August 2, 2012. Dr. Han did not testify at hearing, but his reports were admitted into evidence.

25. In his August 2, 2012 report, Dr. Han indicated that respondent complained of constant neck and right shoulder pain, which only improved with medications. On physical examination, he noted "tenderness and muscle guarding." Dr. Han did not find spasms, reduced range of motion, reduced grip strength, sensory or reflex changes, gross atrophy, or radiculopathy. Dr. Han wrote additional supplemental reports on December 7, 2012 and July 29, 2013, noting no significant changes in respondent's condition.

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[4] Respondent referred to a "Dr. Dennis" in her testimony. Respondent's medical history indicates that Dennis Douglas, M.D. administered cortisone injections on April 7 and May 7, 2014.

AUGUST 22, 2016 RE-EVALUATION BY DR. HAN

26. On August 22, 2016, Dr. Han re-evaluated respondent, and wrote a report. Dr. Han noted that respondent continued to receive care under Toufan Razi, M.D., respondent's primary treating physician. Respondent received chiropractic treatments, physical therapy, acupuncture and cortisone injections into the right shoulder, and one into the neck. Respondent stated that her shoulder injections "helped from a few weeks to up to one year," and her neck injection "helped for three weeks." Repeat neck injections were requested but not authorized. Respondent "completed an orthopedic consultation with Dr. [Douglas] who performed two of the three shoulder injections and offered shoulder surgery. However, she declined surgeries." Respondent also received chiropractic care from David Lamb, D.C., "once or twice monthly to the neck, back, and shoulder. . . ." Respondent complained of throbbing neck pain, constant right shoulder pain radiating outward, and left shoulder pain. She also complained of low back pain.

27. Dr. Han noted that most of respondent's pain was in the right shoulder. Respondent previously declined recommended arthroscopy based on a diagnosis of a labral tear and mild rotator cuff tendinosis. The cortisone injections provided very short-term benefits. Dr. Han recommended a conservative treatment regimen of cryotherapy, moist heat, massage, passive and active range of motion exercises, isometric contractions, dynamic training exercises, and medications as needed. With respect to respondent's cervical spine, Dr. Han noted that respondent had a history of multilevel mild degenerative disc disease and spondylosis. Upon physical examination, respondent had tenderness to light palpation but "normal sensory, motor and reflex and provocation findings bilaterally without suspicion for radiculopathy."

28. Dr. Han noted that respondent's lumbar spine pain was minimal, and recommended conservative management, consisting of therapeutic exercises with intake of anti-inflammatories and muscle relaxers. Dr. Han's objective findings were similar to his findings in his August 2, 2012 report: "On physical examination, there is diffuse multifocal tenderness, muscle guarding, and mild pain reduced range of motion. There are no spasms, sensory or reflex changes, gross atrophy, or radiculopathy."

AUGUST 2, 2017 RE-EVALUATION BY DR. HAN

29. On August 2, 2017, Dr. Han again re-evaluated respondent, and wrote a report. Since his previous examination one year earlier, Dr. Han noted that respondent continued follow-up care with Dr. Razi, who continued her ongoing medication management. Respondent received an "H-wave" electrostimulation unit for home use, which she found helpful. With respect to surgery, respondent clarified that she did not previously decline it, but rather, she wanted to "put it on hold for a short while" due to gallbladder surgery in February 2017. Respondent now wished to return to Dr. Douglas for reconsideration of shoulder arthroscopy.

30. Respondent stated to Dr. Han that she takes Vicodin once daily, Ambien and Flexoril at night, and Tylenol 500 as needed for pain. Respondent complained of constant aching pain in the base of her neck, graded at 8/10 on the pain scale. She had constant aching pain in her right shoulder, graded at 7/10 on the pain scale. She also complained of constant aching in her left shoulder, graded at 4/10 on the pain scale. She also complained of intermittent pain in her left lower back, and muscle spasm in her mid-back.

31. Overall, Dr. Han opined "that a large component of [respondent's] ongoing pain is due to diffuse myofascial pain syndrome of the upper extremities and paraspinals." Dr. Han noted that "there is well-documented evidence that exercise is beneficial for these patients." He further noted, "[a]dditionally, chronic painful conditions, including myofascial pain have shown good response to Duloxetene and Milnacipran and Pregabalin intake and cognitive behavioral therapy and psychological support. I believe all of these strategies may be helpful for the management of this patient's condition." Dr. Han provided no further diagnostic or treatment recommendations. His objective findings were the same as his previous reports.

32. Dr. Han did not provide an opinion on whether respondent was no longer substantially incapacitated from performing the usual duties of a Parole Agent I and should therefore be reinstated from industrial disability retirement.

OCTOBER 17, 2017 PAIN EVALUATION BY TOUFAN RAZI, M.D.

33. On October 17, 2017, Toufan Razi, M.D. saw respondent at the Pacific Pain Institute for pain management, and wrote a report. Dr. Razi did not testify at hearing, but his report was admitted into evidence.

34. Respondent complained of neck, upper back, middle back, left shoulder, right shoulder and right hip pain. She described her pain as moderate to severe. She gained relief from cold and hot applications, topical painkillers, medication, rest, stretching, and use of the H-wave unit.

35. Dr. Razi noted that respondent was experiencing "depressive symptoms." She showed diminished interest in daily activities and had sleepless nights. Her appetite was normal, and her ability to concentrate was intact. Respondent felt fatigued and complained of reduced energy.

36. Dr. Razi performed a physical examination, and made objective findings. He noted tenderness in respondent's cervical spine at C4, C5, C6 and C7. He also noted tenderness in respondent's thoracic spine at T8. Range of motion in respondent's lumbar spine was restricted, with extension limited to 20 degrees and lateral rotation limited to 30 degrees due to pain. On palpation, he noted spasm, tenderness and a tight muscle band on both sides. Respondent's right shoulder movements were restricted due to pain, and he noted tenderness on palpation. Respondent's left shoulder movements were similarly limited, and tender on palpation. Respondent's sensory examination was normal.

37. Dr. Razi recommended a pain management program through the Pacific Pain Institute, consisting of an interdisciplinary evaluation of medical, psychological and musculoskeletal evaluations. Dr. Razi did not provide an opinion on whether respondent was no longer substantially incapacitated from performing the usual duties of a Parole Agent I and should therefore be reinstated from industrial disability retirement.

Discussion

38. Respondent did not retain an expert witness to testify on her behalf for the purpose of whether she met or did not meet the CalPERS standard for reinstatement from industrial disability retirement. Instead, she relied on medical reports provided by her worker's compensation doctors to establish that she continued to be substantially incapacitated from her usual and customary duties as a Parole Agent I. None of her medical providers provided an opinion on this issue, which was the purpose of this hearing.

39. When all the evidence is considered regarding respondent's right shoulder condition, the opinion of Dr. Khasigian that respondent was not substantially incapacitated from performing the usual duties of a Parole Agent I was persuasive. As Dr. Khasigian explained, respondent's pain complaints were not supported by any objective findings. His determination that respondent was not substantially incapacitated from performing the usual duties of a Parole Agent I were supported by his physical examination of respondent.

40. Moreover, Dr. Khasigian's testimony, as a board-certified orthopedic surgeon, was given greater weight than the examinations and reports of Drs. Han and Razi, who specialize in pain medicine. Dr. Khasigian had greater specialized knowledge from an orthopedic standpoint, having those skills, experience, and knowledge concerned with conditions involving the musculoskeletal system.

41. Respondent's assertion that Dr. Khasigian did not consider the objective findings found by respondent's worker's compensation doctors was considered, and rejected. Dr. Khasigian persuasively testified that despite respondent's complaints of high-level pain, it was "not medically reasonable," given that such pain persisted for six years without some significant resolution. Respondent underwent many types of treatment, yet her subjective pain inexplicably continued. Drs. Han and Razi noted subjective reports of pain, but made very little in the way of objective findings. Dr. Han did not find spasms, reduced range of motion, reduced grip strength, sensory or reflex changes, gross atrophy, or radiculopathy with respect to respondent's neck and right shoulder pain. Dr. Razi found tenderness in respondent's neck and shoulders, but made no objective orthopedic findings. Both doctors recommended psychological evaluation and support.

42. Respondent did not provide any competent medical evidence to support her subjective reports of continued pain in her right shoulder. In the absence of sufficient competent medical findings to support respondent's pain complaints, it cannot be found that respondent is substantially incapacitated from performing the usual duties of a Parole Agent I.

43. Because respondent is already receiving industrial disability retirement, the burden was on CalPERS to establish that respondent is no longer substantially and permanently disabled from performing the usual duties of a Parole Agent I. CalPERS presented sufficient competent medical evidence to meet its burden of proof. Consequently, its request that respondent be reinstated from industrial disability retirement should be granted.

LEGAL CONCLUSIONS

1. In accordance with Government Code section 21192, CalPERS re-evaluates members receiving disability retirement benefits who are under the minimum age for service retirement. That section, in relevant part, provides:

> The board . . . may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination . . . . The examination shall be made by a physician or surgeon, appointed by the board. . . . Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency . . . where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of the position with regard to which he or she has applied for reinstatement from retirement.

2. Government Code section 21193 governs the reinstatement of a recipient of disability retirement who is determined to no longer be substantially incapacitated for duty and, in relevant part, provides:

> If the determination pursuant to Section 21192 is that the recipient is not so incapacitated for duty in the position held when retired for disability or in a position in the same classification or in the position with regard to which he or she has applied for reinstatement and his or her employer offers to reinstate that employee, his or her disability retirement allowance shall be canceled immediately, and he or she shall become a member of this system.

3. Government Code section 20026 defines "disability" and "incapacity for performance of duty," and, in relevant part, provides:

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended and

uncertain duration, as determined by the board . . . on the basis of competent medical opinion.

4. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term "incapacity for performance of duty" as used in Government Code section 20026 (formerly section 21022) to mean "the *substantial* inability of the applicant to perform his usual duties." (Italics in original.) In *Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal.App.3d 854, 862 the court held that a disability or incapacity must currently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient.

5. To involuntarily reinstate respondent from industrial disability retirement, CalPERS had to establish that respondent is no longer substantially incapacitated from performing the usual duties of a Parole Agent I. As set forth in Findings 7 through 21, and 38 through 43, CalPERS offered sufficient competent medical evidence at the hearing to meet its burden of proof. Consequently, CalPERS' request that respondent be involuntarily reinstated from disability retirement should be granted.

ORDER

The request of California Public Employees' Retirement System to involuntarily reinstate respondent Tracey A. Portee from industrial disability retirement is GRANTED.

DATED: March 21, 2018

DocuSigned by:
Danette C. Brown
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DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings